FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045484

Facility Name: BRENTWOOD N NSG & REHAB CTR

Address: 3705 DEERFIELD ROAD (Number) RIVERWOODS (City) 60015 (Zip Code)

County: LAKE

Telephone Number: (847) 459-1200 **Fax #** (847) 459-0113

IDPA ID Number: 364445521001

Date of Initial License for Current Owners: 07/21/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) MARVIN FOX, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	248	Skilled (SNF)	248	90,520	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	248	TOTALS	248	90,520	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,438	15,103	19,409	36,950	8
9	SNF/PED					9
10	ICF	6,716	9,394		16,110	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,154	24,497	19,409	53,060	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.62%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/21/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/21/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 248 and days of care provided 15,135

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	448,892	51,020	5,445	505,357		505,357	94	505,451			1
2	Food Purchase		302,460		302,460	(4,073)	298,387	(6,228)	292,158			2
3	Housekeeping	330,825	37,016		367,841		367,841		367,841			3
4	Laundry	111,385	37,902		149,287		149,287		149,287			4
5	Heat and Other Utilities			196,477	196,477		196,477	(4,447)	192,030			5
6	Maintenance	114,512		125,107	239,619		239,619	(24,338)	215,281			6
7	Other (specify):*							698	698			7
8	**TOTAL General Services**	1,005,614	428,398	327,029	1,761,041	(4,073)	1,756,968	(34,221)	1,722,746			8
	B. Health Care and Programs											
9	Medical Director			22,000	22,000		22,000		22,000			9
10	Nursing and Medical Records	3,749,525	240,095	508,657	4,498,277		4,498,277	19,572	4,517,849			10
10a	Therapy		5,353		5,353		5,353		5,353			10a
11	Activities	131,598	42,394		173,992		173,992		173,992			11
12	Social Services	76,666		4,776	81,442		81,442		81,442			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,136	4,136			15
16	**TOTAL Health Care and Programs**	3,957,789	287,842	535,433	4,781,064		4,781,064	23,708	4,804,772			16
	C. General Administration											
17	Administrative	110,189		764,984	875,173		875,173	(620,759)	254,414			17
18	Directors Fees											18
19	Professional Services			101,603	101,603		101,603	1,485	103,088			19
20	Dues, Fees, Subscriptions & Promotions			215,446	215,446		215,446	(158,442)	57,004			20
21	Clerical & General Office Expenses	244,625	122,055	268,881	635,561		635,561	(78,472)	557,089			21
22	Employee Benefits & Payroll Taxes			817,375	817,375	4,073	821,448		821,448			22
23	Inservice Training & Education											23
24	Travel and Seminar			16,651	16,651		16,651	(6,173)	10,478			24
25	Other Admin. Staff Transportation			7,640	7,640		7,640	(5,681)	1,959			25
26	Insurance-Prop.Liab.Malpractice			313,555	313,555		313,555	2,901	316,456			26
27	Other (specify):*							37,238	37,238			27
28	**TOTAL General Administration**	354,814	122,055	2,506,135	2,983,004	4,073	2,987,077	(827,903)	2,159,174			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,318,217	838,295	3,368,597	9,525,109		9,525,109	(838,416)	8,686,693			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR #0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,753	41,753		41,753	544,525	586,278			30
31	Amortization of Pre-Op. & Org.							105,232	105,232			31
32	Interest			52,180	52,180		52,180	754,585	806,765			32
33	Real Estate Taxes			161,573	161,573		161,573		161,573			33
34	Rent-Facility & Grounds			884,839	884,839		884,839	(859,694)	25,145			34
35	Rent-Equipment & Vehicles			19,842	19,842		19,842	(8,224)	11,618			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,160,187	1,160,187		1,160,187	536,424	1,696,611			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		842,986	1,513,138	2,356,124		2,356,124	(25,212)	2,330,912			39
40	Barber and Beauty Shops			32,447	32,447		32,447	(9,909)	22,538			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,780	135,780		135,780		135,780			42
43	Other (specify):*	113,515		45,927	159,442		159,442	(174,629)	(15,187)			43
44	**TOTAL Special Cost Centers**	113,515	842,986	1,727,292	2,683,793		2,683,793	(209,750)	2,474,043			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,431,732	1,681,281	6,256,076	13,369,089		13,369,089	(511,742)	12,857,347			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(117,969)	30		9
10	Interest and Other Investment Income	(1,302)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,389)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(7,849)	24		19
20	Contributions	(18,078)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(224,084)	21		24
25	Fund Raising, Advertising and Promotional	(122,075)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,860)	20		28
29	Other-Attach Schedule	(261,348)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (759,954)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	248,213		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 248,213		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (511,742)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
BRENTWOOD N NSG & REHAB CTR
ID# 0045484
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Credit Card Fees	$ (18,728)	20	1
2	IL Council on LTC (COPE Fees)	(2,328)	20	2
3	Meals	(4,839)	02	3
4	Marketing Salaries	(113,515)	43	4
5	Marketing Consultant	(45,927)	43	5
6	Telephone Revenue	(11,790)	21	6
7	Wheelchair Revenue	(9,337)	25	7
8	Beauty & Barber (to extent of expense)	(9,909)	40	8
9	Cable TV	(6,816)	05	9
10	Seminars (Marketing)	(100)	24	10
11	Office Expense (Bldg Co)	(41)	21	11
12	Licenses & Fees	(200)	21	12
13	Capitalized R&M	(23,223)	06	13
14	Capitalized Painting and Decorating	(1,882)	06	14
15	Non-allowable Auto	(5,720)	25	15
16	Building Company - Accounting Fees	(5,725)	19	16
17	Building Company - Professional Fees	(995)	19	17
18	Non-allowable Legal	(273)	19	18
19				19
20				20
21				21
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97				97
98				98
99				99
100				100
101	Total	(261,348)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				366		(272)						94	1
2	Food Purchase	(6,228)											(6,228)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,816)				2,369							(4,447)	5
6	Maintenance	(25,105)				767							(24,338)	6
7	Other (specify):*						698						698	7
8	**TOTAL General Services**	(38,149)			366	3,136	426						(34,221)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(1,167)	29,722	(8,983)						19,572	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*					4,136							4,136	15
16	**TOTAL Health Care and Programs**				(1,167)	33,858	(8,983)						23,708	16
	C. General Administration													
17	Administrative					144,225	(764,984)						(620,759)	17
18	Directors Fees													18
19	Professional Services	(6,993)	6,720			14,758	(13,000)						1,485	19
20	Fees, Subscriptions & Promotions	(167,069)				8,627							(158,442)	20
21	Clerical & General Office Expenses	(236,115)	241			157,402							(78,472)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar	(7,949)				1,776							(6,173)	24
25	Other Admin. Staff Transportation	(5,720)				39							(5,681)	25
26	Insurance-Prop.Liab.Malpractice					2,901							2,901	26
27	Other (specify):*					37,238							37,238	27
28	**TOTAL General Administration**	(423,846)	6,961			366,966	(777,984)						(827,903)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(461,995)	6,961		(801)	403,960	(786,541)						(838,416)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(117,969)	654,450			8,044							544,525	30
31	Amortization of Pre-Op. & Org.		105,232										105,232	31
32	Interest	(1,302)	753,728			2,159							754,585	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(880,008)			20,314							(859,694)	34
35	Rent-Equipment & Vehicles	(9,337)					1,113						(8,224)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(128,608)	633,403			30,517	1,113						536,424	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			21,963	(47,175)								(25,212)	39
40	Barber and Beauty Shops	(9,909)											(9,909)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(159,442)					(15,187)						(174,629)	43
44	**TOTAL Special Cost Centers**	(169,351)		21,963	(47,175)		(15,187)						(209,750)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(759,954)	640,364	21,963	(47,976)	434,477	(800,615)						(511,742)	45

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Boulevard Healthcare, LLC	100%	(See Attached)		(See Attached)		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Expense	$ 880,008	Brentwood Realty, LLC		$	$ (880,008)	1
2	V	32	Interest Income	2,651	Brentwood Realty, LLC			(2,651)	2
3	V	32	Mortgage Interest		Brentwood Realty, LLC		756,379	756,379	3
4	V	31	Amortization Expense		Brentwood Realty, LLC		105,232	105,232	4
5	V	30	Depreciation Expense		Brentwood Realty, LLC		654,450	654,450	5
6	V	19	Accounting Expense		Brentwood Realty, LLC		5,725	5,725	6
7	V	21	Office Expense		Brentwood Realty, LLC		41	41	7
8	V	21	Licenses & Fees		Brentwood Realty, LLC		200	200	8
9	V	19	Professional Fees		Brentwood Realty, LLC		995	995	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 882,659			$ 1,523,022	$ * 640,364	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$	Advanced Therapy and Rehab, LLC	100.00%	$	$	15
16	V	39	ANCILLARY REHAB	1,504,340	Advanced Therapy and Rehab, LLC	100.00%	1,526,303	21,963	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,504,340			$ 1,526,303	$ * 21,963	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 77,976	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 30,801	$ (47,175)	15
16	V	10	MEDICAL SUPPLIES	1,324	QUALITY CARE MEDICAL SUPPLY	100.00%	157	(1,167)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	366	366	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 79,300			$ 31,324	$ * (47,976)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$ 2,369	$ 2,369	15
16	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	767	767	16
17	V	10	NURSING		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	12,098	12,098	17
18	V	10	SAL-NURSING-M. DEAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	17,624	17,624	18
19	V	15	EMP. BEN.-H.C.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,136	4,136	19
20	V	17	ADMIN SAL-NON-OWNER		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	9,766	9,766	20
21	V	17	ADMIN. SAL.- F. BENJAMIN		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	30,390	30,390	21
22	V	17	ADMIN. SAL - B BENOUDIZ		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	11,854	11,854	22
23	V	17	ADMIN. SAL. - B. CLOCH		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	26,246	26,246	23
24	V	17	ADMIN. SAL. - C. ROSS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	15,494	15,494	24
25	V	17	ADMIN. SAL - S. VAN CAMP		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	20,341	20,341	25
26	V	17	ADMIN. SAL. - M. FILIPPO		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	25,362	25,362	26
27	V	17	ADMIN. SAL. - J. ELOWE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	4,772	4,772	27
28	V	19	PROFESSIONAL FEES		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	14,758	14,758	28
29	V	20	FEES,SUBSCRIPTIONS		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,627	8,627	29
30	V	21	CLERICAL & GENERAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	150,376	150,376	30
31	V	21	SALARIES-ACCTG-B. LARIMORE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	7,026	7,026	31
32	V	24	EDUCATION & SEMINAR		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,776	1,776	32
33	V	25	OTHER ADMIN. STAFF TRANS.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	39	39	33
34	V	26	INSURANCE		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,901	2,901	34
35	V	27	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	37,238	37,238	35
36	V	30	DEPRECIATION		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	8,044	8,044	36
37	V	32	INTEREST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	2,159	2,159	37
38	V	34	OFFICE RENT-UNRELATED		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	20,314	20,314	38
39	Total			$			$ 434,477	$ * 434,477	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	EQUIPMENT RENTAL		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	1,113	$ 1,113	15
16	V	17	CORP ALLOC/MGMT FEE	764,984	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	$	(764,984)	16
17	V	6	REPAIRS AND MAINT.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			17
18	V	7	EMP. BEN.-GEN. SERV.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			18
19	V	10	NURSE CONSULTANT	8,983	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(8,983)	19
20	V	1	DIETICIAN SALARIES	5,445	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	5,173	(272)	20
21	V	7	EMP. BEN.-GEN. ADMIN.		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%	698	698	21
22	V	10A	RESPIRATORY THERAPIST		BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%			22
23	V	43	MARKETING CONSULTANT	15,187	BOULEVARD HEALTHCARE MANAGEMENT, LLC	100.00%		(15,187)	23
24	V								24
25	V	19	HOME OFFICE COST	13,000				(13,000)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 807,599			$ 6,984	$ * (800,615)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Brian Cloch	Owner	Administrative	2.10%	See Attached	7.08	10.89%	Alloc. Salary	$ 1,735	39-7	1
2	Brian Cloch	Owner	Administrative	2.10%	See Attached	7.08	10.89%	Alloc. Salary	26,246	17-7	2
3	Jeff Elowe	Relative	Administrative	2.10%	See Attached	1.3	2.36%	Alloc. Salary	4,772	17-7	3
4	Marilyn Cloch	Relative	Clerical	0	None	38	100.00%	Salary	31,338	21-1	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 64,091		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ADVANCED THERAPY AND REHAB, LLC
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION							1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						1,526,303	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,526,303	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MEDICAL SUPPLY
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						30,801	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						157	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						366	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 31,324	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	404,328	8	$ 18,054	$	53,060	$ 2,369	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	404,328	8	5,848		53,060	767	2
3	10	NURSING	PATIENT DAYS	404,328	8	92,189	90,660	53,060	12,098	3
4	10	SAL-NURSING-M. DEAL	PATIENT DAYS	404,328	8	134,295	134,295	53,060	17,624	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	404,328	8	31,517		53,060	4,136	5
6	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	404,328	8	74,422	74,422	53,060	9,766	6
7	17	ADMIN. SAL.- F. BENJAMIN	PATIENT DAYS	404,328	8	231,575	231,575	53,060	30,390	7
8	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	404,328	8	90,333	90,333	53,060	11,854	8
9	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	404,328	8	200,000	200,000	53,060	26,246	9
10	17	ADMIN. SAL. - C. ROSS	PATIENT DAYS	404,328	8	118,071	118,071	53,060	15,494	10
11	17	ADMIN. SAL - S. VAN CAMP	PATIENT DAYS	404,328	8	155,000	155,000	53,060	20,341	11
12	17	ADMIN. SAL. - M. FILIPPO	PATIENT DAYS	404,328	8	193,262	193,262	53,060	25,362	12
13	17	ADMIN. SAL. - J. ELOWE	PATIENT DAYS	404,328	8	36,364	36,364	53,060	4,772	13
14	19	PROFESSIONAL FEES	PATIENT DAYS	404,328	8	112,461		53,060	14,758	14
15	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	404,328	8	65,740		53,060	8,627	15
16	21	CLERICAL & GENERAL	PATIENT DAYS	404,328	8	1,145,893	1,000,220	53,060	150,376	16
17	21	SALARIES-ACCTG-B. LARIMO	PATIENT DAYS	404,328	8	53,541	53,541	53,060	7,026	17
18	24	EDUCATION & SEMINAR	PATIENT DAYS	404,328	8	13,535		53,060	1,776	18
19	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	404,328	8	300		53,060	39	19
20	26	INSURANCE	PATIENT DAYS	404,328	8	22,107		53,060	2,901	20
21	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	404,328	8	283,762		53,060	37,238	21
22	30	DEPRECIATION	PATIENT DAYS	404,328	8	61,299		53,060	8,044	22
23	32	INTEREST	PATIENT DAYS	404,328	8	16,452		53,060	2,159	23
24	34	OFFICE RENT-UNRELATED	PATIENT DAYS	404,328	8	154,799		53,060	20,314	24
25	TOTALS					$ 3,310,819	$ 2,377,744		$ 434,477	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: BOULEVARD HEALTHCARE MANAGEMEN
Street Address: 8950 GROSS POINT RD. SUITE 600
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENTAL	PATIENT DAYS	404,328	8	8,483		53,060	1,113	1
2										2
3	6	REPAIRS AND MAINT.	PAINTING REVENUE	12,688	2	14,784	14,784			3
4	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	12,688	2	1,994				4
5						$	$			5
6	1	DIETICIAN SALARIES	DIETICIAN REVENUE	41,225	8	39,169	39,169	5,445	5,173	6
7	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	41,225	8	5,282		5,445	698	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 69,712	$ 53,953		$ 6,984	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	LaSalle Bank	X		Mortgage (Bldg Co)			$ 11,000,000	$ 11,000,000			$ 756,379	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank		X	Line of Credit	Interest only	07/20/01	2,000,000	860,000		Prime+1	40,719	6
7	A.I. Credit		X	Insurance Financing	$23,058.00	07/21/02	219,600			8.97%	10,775	7
8	Hill Rom		X	Capital Purchase	$1,780.11	05/15/02	20,573	7,018		7.00%	686	8
9	TOTAL Facility Related				$24,838.11		$ 13,240,173	$ 11,867,018			$ 808,559	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(1,794)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,794)	14
15	TOTALS (line 9+line14)						$ 13,240,173	$ 11,867,018			$ 806,765	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income						$	$			$ (1,302)	1
2	Interest Income (Bldg Co)										(2,651)	2
3	Alloc from Boulevard HC Mgmt										2,159	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (1,794)	21

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	179,836	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	166,409	2
3. Under or (over) accrual (line 2 minus line 1).	$	(13,427)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	175,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	161,573	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000	164,617	11
2001	166,409	12

Adjusted accrual for 2001 per financials

2002 Accrual - $166,409 x 1.05=175,000 (Rounded)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRENTWOOD N NSG & REHAB CTR COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0045484

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-35-200-002	Long Term Care Property	$ 3,273.49	$ 3,273.49
2.	15-35-200-001	Long Term Care Property	$ 161,440.65	$ 161,440.65
3.	15-35-100-003	Long Term Care Property	$ 1,694.41	$ 1,694.41
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 166,408.55	$ 166,408.55

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bil to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BRENTWOOD N NSG & REHAB CTR COUNTY LAKE

FACILITY IDPH LICENSE NUMBE 0045484

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the p cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion home property which is vacant, rented to other organizations, or used for purposes other than long term care n entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is n used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hc (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 t is normally paid during 2001.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 90,758 B. General Construction Type: Exterior Brick/Masonry Frame Metal Frame Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 278,465
2. Number of Years Over Which it is Being Amortized: 5 years; 2 years
3. Current Period Amortization: 105,232
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2001	$ 2,200,000	1
2	Gazebo Property		2001	234,006	2
3	TOTALS			$ 2,434,006	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		8,946,609	448,314		448,314		1,624	68
69	Financial Statement Depreciation			41,753			(41,753)		69
70	TOTAL (lines 4 thru 69)		$ 8,946,609	$ 490,067		$ 448,314	$ (41,753)	$ 1,624	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 8,946,609	$ 490,067		$ 448,314	$ (41,753)	$ 1,624	1
2	WATER HEATER REPAIR	2001	612		20	31	31	41	2
3	LIGHT BALLASTS	2001	612		20	31	31	39	3
4	PLUMBING	2001	880		20	44	44	59	4
5	SIMPLEX LOCK	2001	789		20	39	39	42	5
6	SOFFIT REPAIR	2001	1,025		20	51	51	55	6
7	NETWORK CABLING	2001	20,820		20	1,041	1,041	1,301	7
8	NEWWORK INSTALL	2001	8,215		20	411	411	514	8
9	PLUMBING	2002	889		20	44	44	44	9
10	A/C HEAT EXCHANGER	2002	685		20	34	34	34	10
11	NURSE CALL SYSTEM	2002	2,751		20	275	275	275	11
12	SECURITY KEYPADS	2002	3,000		20	275	275	275	12
13	NURSE CALL SYSTEM	2002	1,807		20	120	120	120	13
14	REPAIR BOILER	2002	2,946		20	135	135	135	14
15	NETWORK CABLING	2002	3,224		20	148	148	148	15
16	AIR CONDITIONING UNIT	2002	6,777		20	226	226	226	16
17	GUTTER CABLES	2002	1,400		20	53	53	53	17
18	ELECTRICAL WIRING	2002	1,747		20	58	58	58	18
19	FIRE ALARM COMPONENTS	2002	6,320		20	158	158	158	19
20	FIRE ALARM COVERS	2002	550		20	14	14	14	20
21	THERMOCOUPLES - BOILER	2002	2,248		20	37	37	37	21
22	REPLACE BOILER #2	2002	10,439		20	130	130	130	22
23	CONDENSOR COIL	2002	529		20	18	18	18	23
24	INSTALL BURNERS	2002	840		20	28	28	28	24
25	A/C REPAIR	2002	848		20	28	28	28	25
26	DRAIN	2002	2,785		20	93	93	93	26
27	DRAIN	2002	694		20	23	23	23	27
28	DOOR	2002	991		20	33	33	33	28
29	ICE REMOVAL ROOF	2002	1,100		20	37	37	37	29
30	TOILET REPAIR	2002	720		20	24	24	24	30
31	ELECTRICAL	2002	1,592		20	53	53	53	31
32	GARBAGE DISPOSAL	2002	1,101		20	37	37	37	32
33	DOOR RELEASE	2002	532		20	18	18	18	33
34	TOTAL (lines 1 thru 33)		$ 9,036,078	$ 490,067		$ 452,060	$ (38,007)	$ 5,773	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 9,036,078	$ 490,067		$ 452,060	$ (38,007)	$ 5,773	1
2	A/C REPAIR	2002	685		20	23	23	23	2
3	CEILING TILES	2002	645		20	22	22	22	3
4	DAMPER	2002	741		20	25	25	25	4
5	BOILER REPAIR	2002	2,259		20	75	75	75	5
6	REPAIR PHONE LINE	2002	1,467		20	49	49	49	6
7	A/C REPAIR	2002	1,034		20	34	34	34	7
8	PAINTING AND DECORATING	2002	1,882		20	94	94	94	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 9,044,790	$ 490,067		$ 452,382	$ (37,685)	$ 6,095	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	248			2001	$ 8,722,400	$ 436,120	35	$ 436,120	$	$	4
5				2002	12,816	1,624	35	1,624		1,624	5
6											6
7											7
8											8
	Improvement Type**										
9	ROOF			12/14/2001	211,393	10,570	20	10,570			9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 8,946,609	$ 448,314		$ 448,314	$	$ 1,624	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,248,253	$ 210,677	$ 126,239	$ (84,438)	10	$ 30,968	71
72	Current Year Purchases	112,525	3,503	7,657	4,154	10	7,657	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,360,778	$ 214,180	$ 133,896	$ (80,284)		$ 38,625	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,839,575	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 704,247	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 586,278	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (117,969)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 44,720	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions	Storage Rental			4,831			4
5	Allocation from Boulevard Healthcare Mgmt.				20,314			5
6								6
7	TOTAL				$ 25,145 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,617 Description: (See Attached)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 88,240	$		$ 88,240	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			22,944			22,944	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			1,401,954			1,401,954	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				620,295		620,295	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						222,691		222,691	13
14	TOTAL			$		$ 1,513,138	$ 842,986		$ 2,356,124	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 76,186	$ 489,401	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,026,389	2,026,389	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	138,385	138,385	6
7	Other Prepaid Expenses	721	721	7
8	Accounts Receivable (owners or related parties)		225,000	8
9	Other(specify): See Supplemental Schedule	150,335	354,235	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,392,016	$ 3,234,131	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		2,434,006	13
14	Buildings, at Historical Cost		8,722,400	14
15	Leasehold Improvements, at Historical Cost	35,649	247,042	15
16	Equipment, at Historical Cost	261,309	2,338,909	16
17	Accumulated Depreciation (book methods)	(52,366)	(1,002,347)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule		129,691	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 244,592	$ 12,869,701	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,636,608	$ 16,103,832	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 884,193	$ 886,167	26
27	Officer's Accounts Payable	107,714	107,714	27
28	Accounts Payable-Patient Deposits	(1)	(1)	28
29	Short-Term Notes Payable	860,000	860,000	29
30	Accrued Salaries Payable	415,542	415,542	30
31	Accrued Taxes Payable (excluding real estate taxes)	34,263	34,263	31
32	Accrued Real Estate Taxes(Sch.IX-B)	175,000	175,000	32
33	Accrued Interest Payable		64,429	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	701,549		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,178,260	$ 2,543,114	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,018	7,018	39
40	Mortgage Payable		11,000,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,018	$ 11,007,018	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,185,278	$ 13,550,132	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (548,670)	$ 2,553,700	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,636,608	$ 16,103,832	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (43,060)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (43,060)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(505,610)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (505,610)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (548,670)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,623,376	1
2	Discounts and Allowances for all Levels	(4,554,070)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,069,306	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,514,377	6
7	Oxygen	3,579	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,517,956	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	42,356	13
14	Non-Patient Meals	4,902	14
15	Telephone, Television and Radio	11,790	15
16	Rental of Facility Space		16
17	Sale of Drugs	903,964	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87,628	19
20	Radiology and X-Ray	17,546	20
21	Other Medical Services	190,089	21
22	Laundry	16,640	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,274,915	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,302	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,302	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,863,479	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,761,041	31
32	Health Care	4,781,064	32
33	General Administration	2,983,004	33
	B. Capital Expense		
34	Ownership	1,160,187	34
	C. Ancillary Expense		
35	Special Cost Centers	2,548,013	35
36	Provider Participation Fee	135,780	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 13,369,089	40
41	**Income before Income Taxes (line 30 minus line 40)****	(505,610)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (505,610)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,309	2,528	$ 93,122	$ 36.84	1
2	Assistant Director of Nursing	1,324	1,420	42,927	30.23	2
3	Registered Nurses	49,894	55,550	1,432,644	25.79	3
4	Licensed Practical Nurses	15,490	16,356	364,694	22.30	4
5	Nurse Aides & Orderlies	115,495	124,998	1,789,685	14.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,931	3,070	59,122	19.26	9
10	Activity Assistants	7,234	7,635	72,476	9.49	10
11	Social Service Workers	2,839	3,055	76,666	25.10	11
12	Dietician					12
13	Food Service Supervisor	3,094	3,459	57,880	16.73	13
14	Head Cook					14
15	Cook Helpers/Assistants	32,899	37,239	391,012	10.50	15
16	Dishwashers					16
17	Maintenance Workers	6,189	7,025	114,512	16.30	17
18	Housekeepers	31,410	34,298	330,825	9.65	18
19	Laundry	13,227	14,064	111,385	7.92	19
20	Administrator	1,846	2,029	78,167	38.52	20
21	Assistant Administrator	1,359	1,417	32,022	22.60	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,443	17,770	244,625	13.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,000	26,453	13.23	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,714	4,248	113,515	26.72	33
34	TOTAL (lines 1 - 33)	306,777	338,161	$ 5,431,732 *	$ 16.06	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	182	$ 5,445	01-03	35
36	Medical Director	Monthly	22,000	09-03	36
37	Medical Records Consultant	96	3,888	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	21,868	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	88	4,776	12-03	45
46	Other(specify)				46
47	Alzheimers Unit	Monthly	14,718	10-03	47
48					48
49	TOTAL (lines 35 - 48)	366	$ 72,695		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7,086	$ 334,630	10-03	50
51	Licensed Practical Nurses	663	23,665	10-03	51
52	Nurse Aides	6,600	109,888	10-03	52
53	TOTAL (lines 50 - 52)	14,349	$ 468,183		53

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TRACY HOOVER	Administrator	0	$ 78,022
MURIEL OSHER	Asst. Administrator	0	32,167
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 110,189

B. Administrative - Other

Description	Amount
Boulevard Healthcare Management	$ 764,984
TOTAL (agree to Schedule V, line 17, col. 3)	$ 764,984
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sachnoff & Weaver	Legal	$ 35,127
Gardner, Carton & Douglas	Legal	1,492
Seyfarth, Shaw	Legal	2,242
FR&R	Accounting	9,538
BDO Seidman, LLP	Accounting	18,754
Bridgemark, LLC	Other Professional	5,500
Document Solutions	Other Professional	245
Personnel Planners	Unemployment Consulting	615
MES/HPSI	Purchasing Consultant	175
Hansen Associates	Architect Fees	1,824
See Attached	Data Processing	13,092
See Attached	Home Office	13,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 101,603

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,173
Unemployment Compensation Insurance	52,646
FICA Taxes	395,049
Employee Health Insurance	192,097
Employee Meals	4,073
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	28,284
Life Insurance	9,330
Disability Insurance	20,067
Other Employee Benefits	12,034
Holiday Expenses	8,694
TOTAL (agree to Schedule V, line 22, col.8)	$ 821,448

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	14,075
Health Care Worker Background Check	480
(Indicate # of checks performed 40)	
Dues & Subscriptions	7,137
Licenses & Permits	3,010
Advertising & Promotion	122,075
Yellow Page Advertising	5,860
Classified Advertising	23,675
Allocation from Boulevard HC Mgmt	8,626
Less: Public Relations Expense	( )
Non-allowable advertising	(122,075)
Yellow page advertising	(5,860)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,004

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Employee Education	680
Seminar Expense	
See Attached	8,021
Allocation from Boulevard HC Mgmt	1,776
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,477

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BRENTWOOD N NSG & REHAB CTR # 0045484 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Council on LTC - $8260.00**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **38,815** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **135,780**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **4,073** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees